AT&T NONMANAGEMENT

Annual Rates of Salary Increases Assumed in Determining SFAS 112 Downsizing Liabilities and Costs

Service in Years t	Rates of Salary increases during year t + .5 to t + 1.5
0	.1900
1	.1300
2	.0900
3	.0700
4	.0625
5	.0600
6	.0580
7	.0570
8	.0562
9	.0556
10	.0552
11	.0547
12	.0543
13	.0540
14	.0538
15	.0537
16	.0536
17 or more	.0535

Source: AT&T experience 1985 - 1989

G

Further Response to Issue No. 50

AT&T BENEFIT CHANGES POST-SFAS 112

Following is a summary of benefit changes and/or new benefits provided since 1993 under the three coverages used in determining the SFAS 112 transition amount.

I. Postemployment Separation Benefits

The Nonmanagement and Management severance pay schedules were improved, as shown in the attached revised schedules for these categories of employees, respectively.

The duration of medical coverage for Management employees entitled to severance benefits was doubled as follows:

	Medical Coverage (Months)	
Service	Old	New
1 year	0	0
1 to 5 years	3	6
5 or more years	6	12

A. AT&T Nonmanagement Severance Schedules

Service (Years)	Manufacturing Weeks Base Pay	Operations Weeks Base Pay
1	1	1
2	2	2
3	3	3
4	4	4
5	5	6
6	6	8
7	7	10
8	9	12
9	11	16
10	13	20
11	15	24
12	17	28
13	19	32
14	21	36
15	24	40
16	28	44
17	32	48
18	36	52
19	40	56
20	45	60
21	50	64
22	55	68
23	60	72
24	65	76
25	70	80
26	75	84
27	80	88
28	85	92
29	90	96
30	95	100
31	100	104
32+	104	104

B. AT&T Management Severance and Supplemental Schedules

Severance Schedule

Service (years)	Weeks Base Pay
0.5	5
1	6
2	7
3	8
4	9
5	10
6	11
7	12
8	13
9	14
10	15
11	16
12	17
13	18
14	19
15	20
16	21
17	22
18	23
19	24
20	25
21	26
22	27
23	28
24	29
25 +	30

Supplemental Schedule
(Employees whose age + service equal 45 years or more)

Combined Whole Years of Age And Service	Additional Weeks Base Pay
45 - 49	2
50 - 54	3
55 - 59	4
60 +	5

Note, employees terminated with a severance benefit who sign a Termination Agreement and Release receive an additional "Release Bonus" equal to 20% of the sum of the Post-Employment Payment and the Post-Employment Payment Supplement (if applicable).

II. Long Term Disability - Income Replacement Benefits

The definition of "eligible pay" for determining Long Term Disability - Income Replacement Benefits for management employees was changed from basic pay to also include certain lump sum payments and differential payments which are included in the definition of compensation under the AT&T Management Pension Plan.

III. Long Term Disability - Medical Benefits

A. Nonmanagement and Management Employees

- ♦ New Mental Health and Chemical Dependency Program (Effective 1/1/96)
  - 50% or 20% employee coinsurance replaced with $10 copayment per visit for in-network service
  - See attached summary (page 6 of this Appendix)
- ♦ New Prescription Drug Program
  (Effective 1/1/95 for Management and 1/1/96 for Nonmanagement)
  - 20% employee coinsurance replaced with $5 (generic)/$10 (brandname) copayment
  - New mail-order drug program
  - See attached summary (page 7 of this Appendix)
- ♦ Changes in Dependent Classifications (Effective 1/1/96)
  - Class I dependent expanded to include Sponsored children i.e., unmarried children age 19 through 23
  - New Class II dependents will no longer receive benefits

B. Nonmanagement Employees

- ♦ Enhancements to In-Network Benefits (Effective 1/1/96)
  - Deductibles are eliminated
  - Coinsurance is discontinued; employee will pay $10 copayment per visit for most services
  - Coverage for certain preventive services has been added:
    - Routine physical exams
    - Immunizations
    - Well-baby care
    - Well-woman care
  - A new $750 per individual annual out-of-pocket maximum

- Changes to Out-of-Network Benefits (Effective 1/1/96)
  - Annual deductible has been increased from $200 to $400 for an individual and from $400 to $800 for a family
  - Annual Out-Of-Pocket maximum has been increased from $1,000 to $2,500 per person, with a new maximum of $5,000 for a family

C. Management Employees

- New POS Option (Effective 1/1/96)
  - See attached summary (pages 8 and 9 of this Appendix)

Mental Health and Chemical Dependency Program (Continued)

New MH/CD Program at a Glance

FOR Participants of all medical options except those enrolled in an HMO.

EFFECTIVE January 1, 1996

ENROLLMENT Automatic—no enrollment necessary.

ADMINISTRATOR This program will be administered separately from your medical coverage by Medco Behavioral Care (MBC).

GENERAL PROVISIONS	YOUR COST	
	In-Network	**Out-of-Network**
ANNUAL INDIVIDUAL DEDUCTIBLE	$0	$200 per person
LIFETIME/ANNUAL BENEFITS MAXIMUM	No maximum	No maximum
ANNUAL OUT-OF-POCKET MAXIMUM	$750 per person	No maximum

BENEFITS	YOUR COST	
INPATIENT HOSPITAL BENEFITS		
Per Admission Copayment	$0	$500
Coinsurance	None	50% of reasonable and customary (R&C) charges
Copayment	$0 for the first 10 days,* $10 per day for each day thereafter	Not applicable
Annual Day Maximum	No maximum for medically necessary treatment	30 days per year *each* for medically necessary MH and CD treatment (reduced by in-network days)
ALTERNATIVE TREATMENT FACILITIES		Not covered out-of-network
Per Admission Copayment	$0	
Coinsurance	None	
Copayment	$0 for the first 10 days,* $10 per day for each day thereafter	
Annual Day Maximum	120 days per year *each* for medically necessary MH and CD treatment	
OUTPATIENT CARE		
Coinsurance	None	50% of R&C charges
Copayment	$0 for the first 10 visits,* $10 per visit for each visit thereafter	Not applicable
Annual Visit Maximum	No maximum for medically necessary treatment	60 visits per year *each* for medically necessary MH and CD treatment (reduced by in-network visits)

* The first 10 days/visits of both mental health and chemical dependency treatment provided in-network each calendar year are covered at no cost to you.

Your New **Prescription Drug**

New Prescription Drug Program at a Glance

FOR Participants of the POS or Traditional Indemnity medical options. (Does not apply to HMO participants.)

EFFECTIVE January 1, 1996

ENROLLMENT Automatic—no enrollment necessary.

ADMINISTRATOR This program will be administered separately from your medical coverage by Medco Containment Services.

	[illegible]	COMMUNITY PHARMACIES	NATIONAL MAIL SERVICE
WHEN TO USE		When you need a prescription drug on a short-term basis (for example, an antibiotic for strep throat)	For prescription medications you use on a regular basis (for example, medication to reduce blood pressure)*
SUPPLY PER PRESCRIPTION (Plus refills)		Up to a 34-day supply**	Up to a 90-day supply
YOUR COST PER PRESCRIPTION*			
At Participating Pharmacies		$5 per generic drug $10 per brand name drug**	$8 per generic drug $15 per brand name drug
At Non-Participating Pharmacies		20% of the prescription cost after meeting the annual deductible (see below)	Not applicable
YOUR ANNUAL OUT-OF-POCKET MAXIMUM FOR PRESCRIPTION DRUGS			
At Participating Pharmacies		$750 per individual (for prescriptions filled at community pharmacies and the mail service)	$750 per individual (for prescriptions filled at the mail service and community pharmacies)
At Non-Participating Pharmacies		No out-of-pocket maximum	Not applicable
CLAIM FORM REQUIRED?			
At Participating Pharmacies		No	No****
At Non-Participating Pharmacies		Yes	Not applicable
ANNUAL DEDUCTIBLE			
At Participating Pharmacies		None	None
At Non-Participating Pharmacies		$50 per individual; $150 per family	Not applicable

* When you first begin taking a new medication that is being prescribed for regular, long-term use, you may want to initially fill your prescription at a participating pharmacy, rather than order a large quantity through the mail service. This will safeguard you against purchasing a 90-day supply of a medication that you may be unable to use if your doctor changes the medication or the dosage.

** Except for injectable insulin, which is available from a participating pharmacy for a $15 copayment (for up to a 90-day supply).

*** If a prescription costs less than your copayment, you pay the lesser amount.

**** An order envelope must be completed when using the mail service.

Medical

The New POS Option: A Detailed Look

GENERAL PROVISIONS	IN NETWORK For Care Provided or Referred by Your PCP	OUT OF NETWORK For Care Not Provided or Referred by Your PCP
ANNUAL DEDUCTIBLE	None	$400 per individual; $800 per family
HOSPITAL ADMISSION COPAYMENT	None	$150 per admission
ANNUAL OUT-OF-POCKET MAXIMUM	$750 per individual*	$2,500 per individual;** $5,000 per family**
LIFETIME MAXIMUM	Unlimited	$1 million

BENEFITS	IN NETWORK For Care Provided or Referred by Your PCP	OUT OF NETWORK For Care Not Provided or Referred by Your PCP
PHYSICIAN OFFICE VISITS— DIAGNOSTIC & TREATMENT SERVICES		
Treatment of Illness or Injury	100% after $10 copayment per visit	80% of R&C after annual deductible
Maternity	100% after one $10 copayment for first visit only	80% of R&C after annual deductible
In-Office Surgery	100% after $10 copayment per visit	80% of R&C after annual deductible
In-Office Lab & X-ray	100% after $10 copayment per visit	80% of R&C after annual deductible
PHYSICIAN OFFICE VISITS— PREVENTIVE SERVICES		
Routine Physical Exam	100% after $10 copayment per visit	Not covered
Well-Baby Care	100% after $10 copayment per visit	Not covered
Immunizations	100% after $10 copayment per visit	Not covered
Well-Woman Care (Self-referral to network OB/GYN once every calendar year)***	100% after $10 copayment per visit	Not covered
Mammography Screening	100% after $10 copayment per visit	80% of R&C after annual deductible
OUTPATIENT SERVICES (Treatment & services performed in other than a physician's office)		
Surgery	100%	80% of R&C after annual deductible
X-ray & Lab Facilities	100%	80% of R&C after annual deductible
Durable Medical Equipment	100%	80% of R&C after annual deductible
INPATIENT SERVICES		
Hospital Room & Board (Semi-private; or private if only room type available or medically necessary)	100%	80% of R&C after annual deductible and $150 per admission copayment
Other Covered Inpatient Services	100%	80% of R&C after annual deductible

[redacted]: The POS option is the new name for the health care network. Your local network remains the same. You may still see your current DOC, except now he or she will be called your PCP (primary care physician). And, you still have a choice each time you need care to go in-network or out-of-network.

[redacted]	IN-NETWORK* (The Care Provided is Ordered by Your PCP)	OUT-OF-NETWORK* (The Care Not Provided or Referred by Your PCP)
EMERGENCY SERVICES		
Emergency Use of Hospital Emergency Room (Or PCP referral)	100% after $40 copayment per visit (waived if admitted)	100% after $40 copayment per visit (waived if admitted)
Non-Emergency Use of Hospital Emergency Room (Without PCP referral)	Paid as out-of-network	80% of R&C after annual deductible and $40 copayment per visit (waived if admitted)
Emergency Ground Ambulance	100%	100%
Emergency Air Ambulance	100% up to $5,000 per occurrence	100% up to $5,000 per occurrence
ALTERNATIVES TO INPATIENT CARE		
Extended Care Facility	100%	80% of R&C after annual deductible; up to 60 days per year
Home Health Care	100%	80% of R&C after annual deductible; up to 100 visits per year
Private Duty Nursing	100%	80% of R&C after annual deductible; up to 100 shifts per year
Hospice Care	100%	80% of R&C after annual deductible; up to 210 days
Birthing Center	100%	80% of R&C after annual deductible
OTHER COVERED SERVICES & PROVIDERS (In-network visits require a PCP referral unless otherwise stated)		
Occupational & Physical Therapy	100% after $10 copayment per visit	80% of R&C after annual deductible
Speech Therapy	100% after $10 copayment per visit	80% of R&C after annual deductible; up to 30 visits per year
Chiropractor**	100% after $10 copayment per visit; up to 60 visits per year (self-referral to a network chiropractor permitted)	80% of R&C after annual deductible; up to 30 visits per year
Podiatrist	100% after $10 copayment per visit	80% of R&C after annual deductible
Acupuncturist	100% after $10 copayment per visit	80% of R&C after annual deductible; up to 30 visits per year
Nutritionist	100% after $10 copayment per visit	Not covered

* Because no claim forms are necessary in-network, it is your responsibility to maintain a record of all in-network and emergency room copayments made by you and your covered dependents. Once you reach the annual out-of-pocket maximum, request a claim form from the HelpLine so further in-network copayments can be reimbursed. Amounts that apply to the in-network out-of-pocket maximum do not apply to the out-of-network out-of-pocket maximum and vice versa.

** Does not include deductibles, copayments or any amounts in excess of reasonable and customary (R&C) limits.

*** In the current health care network, unlimited self-referrals to your obstetrician/gynecologist are covered. In the new POS option, you are still covered for unlimited visits, but you are only allowed one self-referral per year to a network OB/GYN; after that, you need a referral from your PCP.

**** In-network visits are reduced by the number of out-of-network visits and vice versa.

H

ESTIMATE OF SFAS 112 "DOUBLE COUNT" FOR AT&T ASSUMING POSTEMPLOYMENT BENEFIT COST ACCRUALS ARE OF A NATURE TO BE REFLECTED IN THE GDP-PI

This Appendix demonstrates that AT&T would recover only about ten percent of its SFAS 112-related costs through the GDP-PI (assuming, incorrectly in AT&T's view, that such costs were of a nature to be reflected in that index). The reason for the relatively low percentage is that layoff rates at AT&T are disproportionately large relative to those of the economy as a whole. By extension, that means that only a small portion of AT&T's SFAS 112-related costs would be recovered through increases in an economy-wide price measure such as the GDP-PI. AT&T used layoff rates as the basis of comparison because data on severance costs that would be included under SFAS 112 are not available for the U.S. economy as a whole, whereas layoff data are available.

Following are the steps that AT&T followed in developing its estimate:

Step 1: Compute Layoff Rates For AT&T And The U.S. Economy As A Whole

The following computations are based on cumulative data for the period January 1991 through December 1993. AT&T used cumulative data because annual data on layoffs for the U.S. economy as a whole are not available.

A. Layoff Rate at AT&T. AT&T data (excluding Global Information Solutions ("GIS") -- formerly NCR) show the cumulative number of persons laid off in 1991, 1992 and 1993 to be 20,640 (sum of 9,002 in 1991; 6,236 in

1992; and 5,402 in 1993). AT&T's employment for those same years averaged 232,207 (240,983 in 1991; 232,575 in 1992; and 223,063 in 1993). The layoff rate for AT&T is thus: 20,640 / 232,207 or 0.08889.

B. **Layoff Rate in the U.S. Economy.** The U.S. Department of Labor, Bureau of Labor Statistics, in its publication "Worker Displacement During the Early 1990's" (September 14, 1994, Table 4) indicated that cumulative layoffs in 1991 through 1993 totaled 4,137,000. According to the Bureau of Labor Statistics, nonagricultural employment in the 1991-93 period averaged 114,755,667 (113,644,000 in 1991; 114,391,000 in 1992; and 116,232,000 in 1993) (Data obtained from the Department of Labor's publication "Employment and Earnings," December 1994, Table A-1, p. 16).

AT&T could not calculate a layoff rate for the economy as a whole, consistent with that computed for AT&T, simply by dividing cumulative layoffs in 1991-93 by average employment in that period. This is because only a small portion of layoffs for the economy as a whole are subject to the accounting requirements set forth in SFAS 112. Data on exactly what that portion is are not available; therefore, AT&T estimated it by drawing inferences from the two studies described below.

First, AT&T considered a study by Towers Perrin, "Analysis of the Impact of SFAS 112 on the GNP-PI," October 12, 1994, which noted (at p. 5) that "less than 10%

of Towers Perrin clients will recognize any material liabilities under SFAS 112."

Second, AT&T considered a Government Accounting Office (GAO) study, which indicated that only 32% of the private sector's workforce is covered by benefits subject to SFAS 106, the accounting rule relating to the treatment of post-retirement health-care related liabilities of current and retired employees ("Employee Benefits -- Extent of Companies' Retiree Health Coverage," March 1990, p. 6). It is likely that a far greater percentage of workers are covered under SFAS 106 than under SFAS 112. Thus, AT&T considers the 32% figure cited by the GAO to be an upper bound to coverage under SFAS 112.

Combining the Towers Perrin and GAO studies, AT&T believes that the number of laid-off workers subject to SFAS 112 in the economy as a whole falls between 10% and 32%. AT&T conservatively placed that percentage at 25%. Thus, the layoff "rate" for the economy as a whole, adjusted to include only laid-off workers subject to SFAS 112, is equal to: .25 (4,137,000) / 114,755,667 or 0.00901.

Step 2: Compare Layoff Rates For AT&T And The Economy As A Whole

Dividing the AT&T layoff rate (0.08889) by the SFAS 112-adjusted layoff rate for the economy as a whole (0.00901) results in a quotient of 9.86570. What this means is that there is roughly a ten times disproportionality between layoffs at AT&T and those in the overall economy.

Step 3: Derive The GDP-PI Impact As It Relates To AT&T's SFAS-112 Costs

The roughly ten-times disproportionality developed in Step 2 above, suggests that only 10.136% of AT&T's SFAS 112 costs are included within the GDP-PI (100 / 9.86570) and that the balance (89.864%) are not included in the GDP-PI.

AT&T's double count estimate notwithstanding, the fact remains that SFAS 112 is simply a change from cash to accrual accounting. As discussed in AT&T's Pleading Section II, such changes do not affect the underlying economics that drive a business, mainly its cash flow and the value of its assets and liabilities. Because the GDP-PI reflects only economic changes that are included in pricing decisions, SFAS 112-related costs are not accounted for in that index, and thus exogenous treatment even without any offset would not result in any double recovery.